South Carolina Department of Disabilities and Special Needs
Consumer Assessment Team (CAT)
Request for Initial ICF/MR Level of Care

(Use ONLY for First Admission to an ICF/MR)

Date: _____

Consumer: _____

Medicaid #: | | | | | | | | | | |

SSN#: | | | | | | | | | |

Provider: _____

Name of person requesting determination: _____

Address and phone #: _____

LOC Request		**Eligibility Category**	
☐	Initial LOC	☐	Mental Retardation
☐	Not admitted within 30 days of the LOC Determination	☐	Related Disability_____ Specify
☐	Consumer did not meet Provider ICF/MR LOC; review by CAT required	☐	High Risk Infant/At Risk Child
		☐	Spinal Cord Injury
		☐	Head Injury
		☐	Similar Disability_____ Specify

_____ _____
Provider's Director of Nursing (or designee) Date

7/03
Attachment A

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

LEVEL OF CARE

CERTIFICATION LETTER

TO: _____ COUNTY OF RESIDENCE _____

SS#: _____ MEDICAID # _____

LOCATION OF ASSESSMENT: _____

The South Carolina Department of Disabilities and Special Needs has evaluated the information submitted by your physician and other professionals and has determined that:

( ) according to Medicaid criteria, you do not meet medical requirements for Intermediate Care for the Mentally retarded. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long-term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long-term care facility.

( ) according to present Medicaid criteria, you meet requirements to receive long term care at the following level:

( ) Intermediate Care Level for the Mentally Retarded

This letter must be presented to the facility to which you are admitted.

This certification letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

If you disagree with this determination, please read the reverse side of this notification.

EFFECTIVE DATE: _____ EXPIRATION DATE _____

_____
SIGNATURE/TITLE

_____
DATE OF ASSESSMENT

MR/RD (revised 6/99)
Attachment B

LEVEL OF CARE DETERMINATION FOR ICF/MR

NAME _____ **ID** _____ **DOB** _____

1. Person has: (at least one of the following)

   a) MR: _____Yes _____No

   b) Related Disabilities: _____Yes _____No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

AND

2. Supervision is necessary due to: (at least one of the following)

   Impaired judgment/limited capabilities _____ Yes _____ No

   Behavior problems _____ Yes _____ No

   Abusiveness _____ Yes _____ No

   Assaultiveness _____ Yes _____ No

   Drug effects/medical monitorship _____ Yes _____No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

AND

3. Services are needed for: (at least one of the following)

   a) acquisition of behaviors necessary to function with as much self determination and independence as possible _____ Yes _____ No

   b) prevention or deceleration of regression or loss of current optimal functional status. _____ Yes _____ No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

APPROVED FOR ICF/MR LEVEL OF CARE _____ Yes _____ No

_____Initial Determination ____Annual Recertification ____Other (specify)

_____ _____
Signature/Title Date

MR/RD (revised 6/99)

Attachment C

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
LEVEL OF CARE EVALUATION

STAFFING REPORT

Individual's Name: _____

Social Security #: | | | | | | | | | |

The above named individual has been determined by the Office of Consumer Assessment to

☐ meet ☐ not meet

the Medicaid Level of Care criteria for ICF/MR.

Team Member Signatures:

_____

_____

_____

_____

_____

Physician Signature and Date:

_____

Evaluation Date: _____

MR/RD Form 7 (8/99)

Attachment D